percentages will be used to project forward the allowable per diem costs as determined in Subsection 243.06.b. of these rules from the beginning to the midpoint of the Target Period. (7-1-97)

07. Cost Ranking. Prior to October 1 of each year the Director will determine that percent above the median which will assure aggregate payments to ICF/MR providers will approximate but not exceed amounts that would be incurred using Medicare cost principles of reimbursement. That percentage will apply to caps and rates set after September 30 of each year. Projected per diem costs as determined in this Section and subject to the cap will be ranked from the highest to the lowest. The cap will be set at a percent of the bed-weighted median for each rate period. The initial cap will be set as of October 1, 1996. (7-1-97)

a. The median of the range will be computed based on the available data points being considered as the total population of data points. (7-1-97)

b. The cap for each ICF/MR facility with a fiscal year beginning October 1, 1996, will be computed prior to the beginning of that year. For those facilities with a fiscal year ending on a date other than September 30, the first cap will be computed for the period beginning October 1, 1996, and ending on the fiscal year end date. (7-1-97)

c. Facilities with cost reports that transcend the period from October 1, 1996, through September 30, 1997, will be retrospectively settled using the previous reimbursement system for the period of the report up to September 30, 1996. There will not be a retrospective settlement on the portion of these cost reports attributed to October 1, 1996 through the end of the cost report period unless provisions of Section 245 of these rules apply. (7-1-97)

d. Cost reports for periods beginning on or after October 1, 1996, will not be subject to retrospective settlement except as required by other provisions of this chapter. (7-1-97)

e. A new cap and rate will be set for each facility's fiscal year after September 30, 1996. (7-1-97)

f. The cap and prospective rate will be determined and set for each facility's upcoming fiscal year prior to that year and it will not be changed by any subsequent events or information with the exception that if the computations were found to contain mathematical or clerical errors, these errors will be corrected and the cap will be adjusted using the corrected figures. (7-1-97)

g. Payment of costs subject to the cap will be limited to the cap unless the Department determines the exclusions found in Section 247 of these rules apply. (7-1-97)

h. A facility which commences to offer patient care services as an ICF/MR on or after October 1, 1996, shall be subject to retrospective settlement until the first prospective rate is set. Such facility shall be subject to the ICF/MR cap as determined in this chapter. The first prospective rate for this provider will be set by the Department based on quarterly cost statements and final cost reports submitted for periods following the first three (3) months of operation. This first prospective rate may be set after the beginning of the second fiscal year of the provider. For the second year the provider will be paid a rate to be settled retrospectively unless both the Department and the provider agree to a prospective rate or rates covering that fiscal period. (7-1-97)

244. EFFICIENCY INCREMENT FOR ICF/MR.
An efficiency increment will be included as a component of the prospective rate, or retrospective settlement if the allowable capped per diem costs are less than the cap. (7-1-99)T

01. Computing Efficiency Increment. The efficiency increment will be computed by subtracting the projected or, for facilities subject to retrospective settlement the actual allowable per diem costs incurred by the provider, from the applicable cap. This difference will be divided by five (5). The allowable increment is twenty cents ($.20) per one dollar ($1) below the cap up to a maximum increment of three dollars ($3) per patient day. (7-1-97)

02. Determining Reimbursement. Total reimbursement determined by adding amounts determined to be allowable, shall not exceed the provider's usual and customary charges for these services as computed in accordance with this chapter and PRM. In computing patient days for the purpose of determining per diem costs, in those cases where the Medicaid Program or the patient is making payment for holding a bed in the facility, the patient will not be considered to be discharged and thus those days will be counted in the total. (7-1-99)T

245. RETROSPECTIVE SETTLEMENT.
When retrospective settlement is applicable, it is based on allowable reimbursement in accordance with this chapter and based on an audit report. Retrospective settlement will be subject to the same caps and limits determined for prospective payments. (7-1-97)

01. A Provider's Failure To Meet Any Of The Conditions. A provider's failure to meet any of the conditions of participation set forth in 42 CFR 483, Subpart I, may subject that provider to retrospective reimbursement for the fiscal year, or any portion thereof, during which the condition is not met. The provider's projected per diem rate may be adjusted to reflect actual reimbursable costs subject to cost limits. (7-1-97)

02. A First Time Provider. A first time provider operating a new ICF/MR living unit will be subject to a retrospective settlement for the first fiscal year and until the first subsequent period wherein a prospective rate is set in accordance with Sections 203, 204, and 243 and this chapter. A budget based on the best available information is required prior to opening for patient care so an interim rate can be set. (7-1-97)

03. New ICF/MR Living Unit. A new ICF/MR living unit for an existing operator is subject to first time facility requirements if the new living unit reflects a net increase in licensed beds, otherwise the Department may set a prospective rate with the nonproperty rate components based on similar components of rates most recently paid for the patients moving into the facility. The property rental rate will be set according to applicable provisions of this chapter. (7-1-97)

04. Change Of Ownership Of Existing ICF/MR Living Unit. Where there is a change of ownership of an existing ICF/MR living unit, the provider operating the ICF/MR living unit will not receive an adjustment of the provider's prospective rate except that the property rental portion of the rate will be adjusted subject to property rental provisions of this chapter. However, new facility reporting requirements and the cap will apply. (7-1-97)

05. Fraudulent Or False Claims. Providers who have made fraudulent or false claims are subject to retrospective settlement as determined by the Department. (7-1-97)

06. Excluded Costs. Excluded costs may be retrospectively settled according to the provisions of Section 247 of these rules. (7-1-97)

246. EXEMPT COSTS.
Exempt costs are not subject to the ICF/MR cap. (7-1-97)

01. Day Treatment Services. As specified in this Section, the cost of day treatment services may be reimbursed in this category and may not be subject to the ICF/MR cap. (7-1-97)

a. This category includes the direct costs of labor, benefits, contracted services, property, utilities and supplies for such services up to the limitations provided in this Subsection. (7-1-97)

b. When a school or another agency or entity is responsible for or pays for services provided to a patient regularly during normal working hours on weekdays, no costs will be assigned to this category for such services. The Department will not reimburse for the cost of services which are paid for or should be paid for by an other agency. (7-1-97)

c. When ICF/MR day treatment services are performed for patients in a licensed Developmental Disability Center, the allowable cost of such services shall be included in this category, but not more than the amount that would be paid according to the Department's fee schedule for individual or group therapy for similar services. Amounts incurred or paid by the ICF/MR in excess of what would be paid according to the Department's fee schedule for like services are not allowable costs and shall be reported as nonreimbursable. (7-1-97)

d. For day treatment services provided in a location other than a licensed developmental disability center, the maximum amount reportable in this category shall also be limited. Total costs for such services reported by each provider in this category shall be limited to the number of hours, up to thirty (30) hours per week per client, of individual or group developmental therapy times the hourly rate that would be paid according to the most recent Department fee schedule for the same services if provided in a developmental disability center. Costs in excess of the limits determined in this Subsection shall be classified and reported as subject to the ICF/MR cap. Initial rates established under the prospective system effective October 1, 1996, and not later than October 1, 1997, will not include a limitation of day treatment costs based on the hourly rate, when the hours of individual or group therapy were not obtained or audited by the Department at the time the rate was published. However, if a provider believes that the day treatment cost used to establish the day treatment portion of its prospective rate was misstated for rates set for periods beginning October 1, 1996, through rates beginning October 1, 1997, revisions to the prospective rate may be made to the extent the provider demonstrates, to the satisfaction of the Department, that the cost used was misstated. Such a revision will be considered only if the provider requests a revision and provides adequate documentation within sixty (60) days of the date the rate was set. At the option of the Department it may negotiate fixed rates for these day treatment services. Such rates shall be set so the aggregate related payments are lower than would be paid with a limitation based on schedules used for licensed Developmental Disability Centers. (7-1-97)

e. Financial data including expenses and labor hours incurred by or on behalf of the provider in providing day treatment services, must be identifiable and separate from the costs of other facility operations. Reasonable property costs related to day treatment services and not included in the property rental rate, shall be separately identified, shall be reported as day treatment services costs, and shall not include property costs otherwise reimbursed. Property costs related to day treatment services shall be separately identified as not related to living unit costs by a final audit determination issued prior to October 1, 1996, or shall be separate and distinct from any property used for ICF/MR services which are or were day treatment services. (7-1-97)

f. In the event a provider has a change in the number of patients requiring day treatment services, the prospective rate may be adjusted by the Department to reflect a change in costs related to such a change. Providers receiving such changes may be required to provide added documentation to the Department to assure that further changes can be identified and the prospective rate adjusted accordingly. (7-1-97)

02. Major Movable Equipment. Costs related to major movable equipment, as defined in this chapter shall be exempt from the ICF/MR cap and shall be reimbursed prospectively based on Medicare principles of cost reimbursement. (7-1-97)

247. COSTS EXCLUDED FROM THE CAP.

Certain costs may be excluded from the ICF/MR cap, may be subject to retrospective settlement at the discretion of the Department, and may result in changes to the prospective rate as provided in this Section to assure equitable reimbursement: (7-1-97)

01. Increases Of More Than One Dollar Per Patient Day In Costs. Increases of more than one dollar ($1) per patient day in costs otherwise subject to the cap incurred by a facility as a result of changes in State or Federal laws or rules will be reported separately on the cost report for reports filed less than thirty (30) months, or a greater length of time if so directed by the Department, from the date such increases were first required. Such costs will be subdivided into the component parts of wages, benefits, contracted services and other costs in the amounts equal to costs removed from the respective cost categories subject to the cap. The Department may adjust the forecasted rate to include the projected per diem related to such costs. (7-1-97)

a. The provider shall report these costs on a separate schedule or by notations on the cost report so that these costs can be identified and reconciled to the provider's general ledger. (7-1-97)

b. If more than one (1) increase occurs as a result of one (1) or more law or rule change, the costs from each event are to be reported separately. (7-1-97)

c. The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department states otherwise. (7-1-97)

c. For interim rate purposes the provider's prospective rate may be granted an increase to cover such cost increases. A cost statement covering a recent period may be required with the justification for the increased costs. The actual amount related to such increases will be determined at audit and may be retrospectively settled. (7-1-97)

e. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at it's option, include all of the previously excluded costs related to those increases with costs subject to the cap when setting rates or increase the cap and individual facility prospective rates following such cost increases. If a cap is set with these particular costs included in the cap category, providers subject to that cap will not have these costs excluded from the cap for prospective rate purposes. The intent of this provision is for costs to be exempt from the cap until these costs are able to be fully and equitably incorporated in the data base used to project the cap and for these costs to be exempt only when they are not included in the data base. In those cases, when costs are not incurred immediately after a change in rule or law, delays in incorporating the new costs in the cap are warranted. (7-1-97)

f. When cost increases which have been excluded from the cap are incorporated in the inflation indices used to set the cap, the cost indices will be adjusted to exclude the influence of such changes if the amount is included in the index is identified. When the cap is set to include previously excluded amounts, any adjustments previously made to the indexes related to the previously excluded costs will be removed. (7-1-97)

02. Excess Inflation. Reimbursement of costs subject to the cap will be limited to the cap unless the Department determines the inflation indices used to set the prospective rates for a reporting period understated actual inflation by more than seven (7%) percentage points. In such case, prospective rates and the cap will be increased by the amount which actual inflation indices exceeded projected inflation indices and may be retrospectively adjusted by the department. (7-1-97)

03. Cost Increases Greater Than Three Percent. Cost increases greater than three percent (3%) of the projected interim rate which result from disasters such as fire, flood, or earthquake, epidemic or similar unusual and unpredictable circumstances over which a provider has no control. In such case, prospective rates will be increased and will not be subject to the cap, by the amount which actual inflation indices exceeded projected inflation indices and may be retrospectively adjusted by the Department for purposes of this Subsection, disaster does not include personal or financial problems. (7-1-97)

04. Decreases. In the event of state or federal law, rule, or Policy changes which result in clearly identifiable reductions in required services, the Department may reduce the prospective rate to reflect the identified per diem amount related to such reductions. (7-1-97)

05. Prospective Negotiated Rates. Notwithstanding the provisions of Sections 240 through 246, the Director shall have the authority to negotiate prospective rates for providers who would otherwise be subject to accept retrospective settlement. Such rates shall not exceed the projected allowable rate that would otherwise be reimbursed based on provisions of this chapter. (7-1-97)

248. -- 249. (RESERVED).

250. COST LIMITS FOR NURSING FACILITIES.
Sections 250 through 312 of these rules, provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the nursing home reimbursement system as specified in Sections 56-101 through 56- 135, Idaho Code. All audits related to fiscal years ending on or before December 31, 1999 are subject to rules in effect before July 1, 1999. (7-1-99)T

251. PRINCIPLE.
Providers of nursing home services will be paid at the allowed amount determined in accordance with Section 56-101 to 56-131, Idaho Code. Total payment will be made up of the total of the following components: (7-1-99)T

01. Property And Utility Costs. All allowable property and utility costs; (9-15-84)

02. Nonproperty, Nonutility Costs. Nonproperty nonutility costs as determined in accordance with the above mentioned Sections of the Idaho Code. (9-15-84)

03. Efficiency Increment. An efficiency increment determined in accordance with the above mentioned Sections of the Idaho Code. (1-1-82)

04. Exempt Costs. Other allowable costs exempt from the percentile cap under Sections 56-110(b) and 56-117, Idaho Code, as specified in Subsection 254.08 and 254.09. (12-31-91)

252. PROPERTY AND UTILITY COSTS.
The allowability of each of these cost items will be determined in accordance with other provisions of this chapter, or the PRM in those cases where this the rules of this chapter are silent or not contradictory. Total property and utility costs are defined as being made up of the following cost categories. The Department may require and utilize an appraisal to establish those components of property costs which are identified as an integral part of an appraisal. (7-1-99)T

01. Depreciation. All allowable depreciation expense. (1-1-82)

02. Interest. All allowable interest expense relating to financing building and equipment purchases. Interest on working capital loans will be included as administrative costs. (1-1-82)

03. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances will not be considered to be property costs. (1-1-82)

04. Lease Payments. All allowable lease or rental payments. (1-1-82)

05. Property Taxes. All allowable property taxes. (1-1-82)

06. Utility Costs. All allowable expenses for heat, electricity, water and sewer. (9-15-84)

253. -- 299. (RESERVED).

300. RATE SETTING.
The objectives of the rate setting mechanism for nursing facilities are: (7-1-97)

01. Payments. To make payments to nursing facilities through a prospective cost-based system which includes facility-specific case mix adjustments. (7-1-99)T

02. Rate Adjustment. To set rates based on each facility's case mix index on a quarterly basis and establishing rates that reflect the case mix of that facility's Medicaid residents as of a certain date during the preceding quarter. (7-1-99)T

301. PRINCIPLE.
Reimbursement rates will be set based on projected cost data from cost reports and audit reports. Reimbursement is to be set for freestanding and hospital-based facilities. In general, the methodology will be a cost-based prospective reimbursement system with an acuity adjustment for direct care costs. (7-1-99)T

302. DEVELOPMENT OF THE RATE.
Rates shall be rebased annually. Rate setting shall be prospective with new rates effective July 1 of each year. There will be no settlement between actual costs incurred during the rate year and the rate itself. Rates for nursing facilities with unaudited cost reports will be interim rates established by the Department until a rate is calculated based on an audited cost report. The draft audit of a cost report submitted by a facility shall be issued by the Department no later than five (5) months from the date all information required for completion of the audit is filed with the Department. Data used to develop the reimbursement rate for nursing facilities will be made up of the following components: (7-1-99)T

01. Property Reimbursement. Per diem property costs as shown on the latest twelve (12) month cost report or audit report whichever is to be used in accordance with the cost reporting standards specified in Subsection 302.07. and the property rental rate as determined by Section 060, for facilities which receive this rate in lieu of property costs. No inflationary increase will be considered for property costs for the purpose of developing the interim rate. The property reimbursement component will be calculated in accordance with Section 060 of these rules. (7-1-99)T

02. Utility Costs. Projected utility costs for the facility's upcoming fiscal year may be submitted to the Department not less than ninety (90) days prior to the beginning date of the facility's upcoming fiscal year. In the absence of such submission the Department will project the facility's utility costs utilizing the methodologies found in Subsection 302.07. (7-1-99)T

03. Direct Care Component. The direct care component of a facility's rate is the lesser of the facility's inflated direct care costs per resident day as defined in subsection 004.27 and for the cost report period discussed in subsection 302.07 adjusted for inflation in accordance with subsection 004.42 and 004.43 or the direct care cost limit discussed in subsection 303.02 for that type of provider (free-standing nursing facility and urban hospital-based nursing facility, or rural hospital-based nursing facility). The lesser of the inflated direct care costs per resident day subject to subsection 302.03.a or the applicable direct care cost limit also subject to subsection 302.03.a and as adjusted in subsection 302.03.b is then case mix adjusted, based in the facility's Medicaid case mix index as discussed in subsection 302.03.c. (7-1-99)T

a. All costs included in the direct care component will be adjusted based on the facility's case mix indices, with the exception of raw food and Medicaid related ancillary costs. (7-1-99)T

b. The direct care cost limits will be adjusted based on each facility's case mix index. The calculated direct care cost limit will be divided by the statewide average facility-wide case mix index, and then multiplied by the individual facility-wide case mix index. (7-1-99)T

c. The lesser of the inflated direct care costs per resident day or the applicable direct care cost limit will be divided by the facility-wide case mix index, and then multiplied by the most recent quarterly Medicaid case mix index to arrive at the direct care component. (7-1-99)T

04. Indirect Care Component. The indirect care component of a facility's rate is the lesser of the facility's inflated indirect care costs per resident day as defined in subsection 004.41 and for the cost reprot period discussed in aubsection 302-07 adjusted for inflation in accordance with subsection 004.42 and 004.43, or the indirect care cost limit for that type of provider (freestanding nursing facilities and urban hospital-based facilities, or rural hospital-based facilities). (7-1-99)T

05. Efficiency Incentive. The efficiency incentive is available to those providers, both freestanding and hospital-based, which have inflated per diem indirect care costs less than the indirect per diem cost limit for that

type of provider. The efficiency incentive is calculated by multiplying the difference between the per diem indirect cost limit and the facility's inflated per diem indirect care costs by seventy percent (70%). There is no incentive available to those facilities with per diem costs in excess of the indirect care limit, or to any facility based on the direct care component. (7-1-99)T

06. Calculated Reimbursement Rate. The reimbursement rate for a facility will be the sum of the Direct Care Component, Indirect Care Component, Efficiency Incentive, Cost Exempt from Limitation, and Property Reimbursement. In no case will the prospective reimbursement rate be set higher than the charge for like services to private pay patients in effect for the period for which payment is being made as computed by the lower of costs or customary charges. (7-1-99)T

07. Cost Component. The cost component of each facility's rate shall be established effective July 1 of each year and remain in effect through the following June 30. The cost data used in establishing the cost component of the rate calculation will be from the audited or unaudited cost report which ended during the previous calendar year (i.e., cost reports ending during the period from January 1, 1998 - December 31, 1998 will be used in setting rates effective July 1, 1999). If unaudited data is used, the rate will be considered an interim rate until the audited data is available, at which time a retroactive adjustment to the payment rate will be made. (7-1-99)T

08. Case Mix Component. The Medicaid case mix indices used in establishing each facility's rate will be recalculated quarterly and each facility's rate will be adjusted accordingly. The case mix indices will be calculated based on the most recent assessment for each resident in the facility on the first day of the second month of the preceding quarter (i.e., assessments as of May 1, 1999 would be used to establish the case mix indices needed to establish rates for the quarter beginning July 1, 1999. (7-1-99)T

303. COST LIMITS.

Effective July 1, 1999, and each July 1 thereafter, the direct care and indirect care components shall be subject to cost limits. The cost limits shall be based on the most recent audited cost report with an end date of June 30 of the previous year or before (the base year), and will be effective for a one-year period. Each component shall have two cost limits, one applicable to both free-standing and urban hospital-based nursing facilities and the second for rural hospital based nursing facilities. (7-1-99)T

01. Basis for the Costs Limits. Prior to establishing the first "shadow rates" (the prospective rates at July 1, 1999), Medicaid payments for the period from July 1, 1999 through June 30, 2000 shall be calculated using the previous retrospective system. This calculation shall be used to establish the cost limits effective July 1, 1999specifically, to provide that the direct and indirect care components of the prospective rates reflect the following: (7-1-99)T

a. A level of Medicaid expenditures that approximates the same amount under the retrospective system.
b. The same distribution of total Medicaid dollars between the hospital-based and free-standing nursing facilities.
c. That direct care costs are higher than indirect care costs.
d. That rural hospital-based nursing facilities shall have higher cost limits than free-standing and urban hospital-based nursing facilities.

Once established, the percentage calculated as a result of these conditons will remain in effect for future rate setting periods.

02. Direct Cost Limits. 02. Direct Care Cost Limits. Direct care costs as defined in §§004.27 for the base year shall be adjusted for inflation in accordance with §§004.42 and .43. Inflation adjusted direct care costs (excluding ancillary and raw food costs) per resident day are next "normalized" to make these costs comparable among facilities. In accordance with §§004.69 the normalized costs per resident day are derived by dividing each facility's inflation adjusted cost per resident day excluding ancillary and raw food costs by its facility-wide case mix index (¶004.12.a) for the base year and multiplying the results by the state-wide average case mix index (¶004.12.c). Direct care ancillary and food costs are not subject to case mix adjustments. However, in determining the direct

care component of a facility's prospective payment rate, all direct care costs are case mix adjusted per ¶302.03.c. To reverse this effect, in determining the direct care cost limits, the inflation adjusted ancillary and raw food costs per resident day are adjusted by the quotient of the facility wide case mix index divided by the facility's Medicaid case mix index for the base year. The total direct care costs per resident day (the case mix adjusted costs per resident day plus the adjusted ancillary and raw food costs per resident day) are then arrayed (sorted) from the highest to the lowest. A cumulative bed level is determined for each facility, beginning with that facility with the highest total direct care costs per resident day. The number of licensed beds for that facility are added to the number of beds of the next highest cost facility, resulting in a bed level for the second facility consisting of the number of its beds plus the number of beds of the highest total direct care cost perdiem. This sequential cumulation continues until the facility with the lowest total direct cost perdiem is included and a total bed level is determined. A median bed level shall be determined and the total direct care costs per resident day for the facility at the median bed level becomes the basis for the direct care cost limits. The direct care cost limits shall be determined by applying the conditions described in §§303.01 to the total direct care costs per resident day of the facility at the median bed level. (7-1-99)T

03. Indirect Cost Limits. Indirect care costs as defined in §§004.42 and for the same reporting year used to determine the direct cost limits shall be adjusted for inflation. To arrive at the indirect care costs, indirect care costs for ancillary services in the base year cost report were Medicaid specific and an adjustment had to be made to arrive at a facility-wide level. The methodology used to determine the direct care cost limits excluding normalizing per resident day and case mix adjustments, but including arraying the costs per resident day, identifying that costs per resident day at the median bed level, and subjecting that Costs per resident day to the conditions described in §§303.01 shall also be employed to determine the indirect care cost limits. (7-1-99)T

04. Limitation On Increase Or Decrease Of Cost Limits. Increases in the direct and indirect cost limits shall be determined by the limitations calculated effective July 1, 1999, indexed forward each year by the inflation factor plus two percent (2%) per annum. Furthermore, the calculated direct and indirect cost limits shall not be allowed to decrease below the established limitations effective July 1, 1999. The maximum rate of growth on the cost limits, and the minimum cost limitation, will be examined by the oversight committee after a three-year period to determine which factors to use in the calculation of the limitations effective July 1, 2002 and forward. (7-1-99)T

05. Costs Exempt From Limitations. Costs exempt from limitations include property taxes, property insurance, and utilities. These costs will be reimbursed on a per diem basis and will not be included in the calculation of the direct or indirect care component. However, property taxes and property insurance will be subject to minimum occupancy levels as defined in Section 123. (7-1-99)T

304. TREATMENT OF NEW BEDS.

Facilities which add beds subsequent to the effective date of these rules (July 1, 1999), will have their reimbursement rates subjected to an additional limitation for the next three (3) full years. This limitation will apply beginning with the first rate setting period that utilizes a cost report that includes the date(s) when the beds were added and will be re-determined each July 1 thereafter. The facility's rate will be limited to an average of two rates (2). The calculation is as follows: (7-1-99)T

01. Calculation of the New Bed Rate. The number of beds in existence prior to the additions will be multiplied by 365 or 366 (the number of days in the cost report year). The resulting total days will then be multiplied by the current payment rate calculated in accordance with §302. Each new bed will be multiplied by the number of days in the cost reporting period that the bed was in service. The total number of days for all new beds will then be multiplied by the current median rate for facilities of the same type (freestanding, urban hospital-based, or rural hospital-based). The sum of the amounts calculated in §§304.1 and §§304.02 will then be divided by the sum of the total days applicable to beds in existence prior to the addition and the new beds. The resulting per diem will represent an overall limitation on the facility's reimbursement rate. Providers with rates calculated in accordance with §302 that do not exceed the limitation will receive their calculated rates. (7-1-99)T